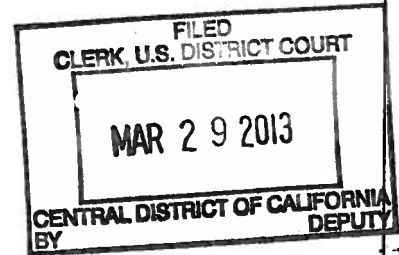


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11 ATTORNEYS FOR PLAINTIFF  
12 VALLEY SURGICAL CENTER, LLC

13 UNITED STATES DISTRICT COURT  
14 FOR THE CENTRAL DISTRICT OF CALIFORNIA  
15 WESTERN DIVISION

16 VALLEY SURGICAL CENTER, LLC, a California Limited Liability  
17 Company,  
18

19 Plaintiff,

20 vs.

21 COUNTY OF LOS ANGELES, a  
government entity, LAKSHMANAN  
22 SATHYAVAGISWARAN, M.D., an  
individual, ADRIAN MARINOVICH,  
23 M.D., an individual, RAFFI  
DJABOURIAN, M.D., an individual,  
24 DENIS C. ASTARITA, M.D., an  
individual, SELMA CALMES, M.D.,  
25  
26

COMPLAINT FOR DAMAGES  
AND INJUNCTIVE RELIEF:

1. VIOLATIONS OF  
CONSTITUTIONAL RIGHTS  
UNDER 42 U.S.C. § 1983
2. VIOLATIONS OF  
CONSTITUTIONAL RIGHTS  
UNDER 42 U.S.C. § 1983 -  
MONELL AND SUPERVISORY  
LIABILITY
3. VIOLATIONS OF STATE LAW
4. INJUNCTIVE RELIEF

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COMPLAINT FOR DAMAGES  
AND INJUNCTIVE RELIEF

1 **an individual, JOHN KADES, an**  
 2 **individual, ED WINTER, an**  
 3 **individual, and DOES 1-10,**

4 **Defendants.**

**DEMAND FOR JURY TRIAL**

**INTRODUCTION**

5  
 6  
 7 1. For the past nineteen months, the Los Angeles County Coroner's  
 8 Office ("Coroner's Office") has been pursuing what can only be described as a  
 9 vendetta against Valley Surgical Center, LLC ("Valley"), arising out of its  
 10 investigation into the death of Paula Rojascki after weight loss surgery at Valley.  
 11 The Coroner's Office has systematically engaged in conduct violating Valley's  
 12 constitutional rights. The Coroner's Office and its representatives have falsified  
 13 the available and known evidence regarding the Rojascki surgical procedure and  
 14 misrepresented the cause of death by contending that this fabricated evidence  
 15 demonstrates that the surgical procedure caused the death. The Coroner's Office  
 16 has forwarded the same fabricated evidence to the LAPD Robbery-Homicide  
 17 Division and to the next of kin of Paula Rojascki. In violation of the Coroner's  
 18 Office own Security Hold, the Coroner's Office has leaked aspects of the as yet  
 19 unreleased autopsy report and investigation to the media. A Coroner's Office  
 20 representative, at a public forum, referred to the supposed facts she found and  
 21 presented false facts that were readily identifiable as a reference to the Rojascki  
 22 death at Valley.

23 2. Far from being an impartial investigative body seeking the truth, the  
 24 Coroner has demonstrated a clear bias against Valley, which disqualifies it from  
 25 continuing to investigate the Rojascki death. This bias has been manifested by,  
 26

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**COMPLAINT FOR DAMAGES  
 AND INJUNCTIVE RELIEF**

1 *inter alia*, (1) using a principal investigator who is a strident advocate of banning  
 2 ambulatory surgery centers from performing weight loss surgery and who was the  
 3 person whose initial report fabricated and falsified the surgical evidence on which  
 4 the Coroner has systematically relied; (2) placing a supposed "security hold" (the  
 5 legal basis of which has never explained) on its investigation to justify not  
 6 communicating its report to Valley while simultaneously communicating it to  
 7 others, including the Rojeski family; (3) threatening to release the autopsy report –  
 8 the investigation of which has to date taken 19 months – if Valley or anyone else  
 9 were to publicly disclose or complain of the wrongful actions of the Coroner's  
 10 Office; (4) relying on the unverified allegations of an anonymous source; and (5)  
 11 obtaining access to Valley's surgical offices by presenting a subpoena demanding  
 12 access for which it did not have the legal authority represented in the subpoena.

13 3. The Coroner's actions (not all of which are recounted above) have  
 14 resulted in numerous violations of Valley's constitutional rights and state laws and  
 15 the liberty and property interests protected by these state laws, including violations  
 16 of due process based on the deliberate falsification of evidence in the autopsy and  
 17 use of that report to trigger a criminal investigation, recommending disciplinary  
 18 proceedings, and jeopardizing Valley's accreditation. In addition, the Coroner's  
 19 Office has intimidated and chilled Valley's exercise of its rights to free speech, to  
 20 petition the government, and to access the courts, violated its right to be free from  
 21 unreasonable search and seizure, deprived it of procedural and substantive due  
 22 process of law, and deprived it of equal protection of the law. Defendants have  
 23 engaged in a systematic campaign lasting over a year resulting in the deprivation  
 24 of Valley's constitutional rights and threatened its very existence in doing so.

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 AND INJUNCTIVE RELIEF

1           4.     It is the Coroner's repeated threats to release the extant autopsy report  
2 that brings Valley to seek *ex parte* relief, i.e., for a Temporary Restraining Order  
3 to restrain the Coroner from taking further action, including release of the extant  
4 autopsy report or any modified report pending a hearing on Valley's motion for  
5 preliminary injunction, at which Valley will request that the Coroner be  
6 preliminarily (and ultimately permanently) enjoined from further participation and  
7 investigation into the death of Paula Rojascki or forwarding or divulging its current  
8 report or any variant thereof. (This would not preclude Los Angeles County from  
9 requesting that a coroner from another county or other independent body be  
10 appointed to complete the investigation and issue a report not based on fabricated  
11 evidence).

12           5.     There is a grave likelihood that Valley's very existence will be fatally  
13 destroyed if this Court does not act. Valley has already been severely damaged by  
14 the conduct at issue in this case – its business has dramatically declined due to the  
15 cloud over its head because of the implication that Ms. Rojascki died due to  
16 Valley's actions, and it has spent large sums of money (including attorneys and  
17 expert consultants) defending itself against the fabricated evidence and other  
18 conduct of the Coroner's Office. If this false report is allowed to issue, Valley will  
19 likely have its accreditation and certification withdrawn by The Joint Commission,  
20 which accredits health care facilities in California. Without that accreditation,  
21 Valley will be forced to close its doors.

22                           **PARTIES**

23           6.     Plaintiff Valley Surgical Center, LLC, is a California limited liability  
24 company with a principal place of business in the County of Los Angeles.  
25  
26

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1           7. Defendant County of Los Angeles is a government entity operating  
2 under the laws of the State of California. Defendant County of Los Angeles  
3 oversees the Department of the Coroner (hereinafter collectively referred to as the  
4 “Coroner’s Office”). The Coroner’s Office is a governmental entity operating  
5 under the laws of the State of California and also operating under the regulations  
6 of the County of Los Angeles.

7           8. Defendant Lakshmanan Sathyavagiswaran, M.D. is an individual  
8 employed by the County of Los Angeles and is officially listed as the Interim Head  
9 of the Los Angeles County’s Department of the Coroner (“Sathyavagiswaran”). He  
10 is being sued in his individual and official capacities.

11           9. Defendant Adrian Marinovich, M.D. is an individual who was  
12 employed by the County of Los Angeles (“Marinovich”). He is being sued in his  
13 individual capacity.

14           10. Defendant Raffi Djabourian, M.D. is an individual employed by the  
15 County of Los Angeles as Senior Deputy Medical Examiner (“Djabourian”). He is  
16 being sued in his individual capacity.

17           11. Plaintiff is informed, believes, and thereon alleges that Defendant  
18 Denis C. Astarita, M.D. is an individual retained by the Coroner’s Office as an  
19 outside consultant with the title of Deputy Medical Examiner (“Astarita”). He is  
20 being sued in his individual capacity.

21           12. Plaintiff is informed, believes, and thereon alleges that Defendant  
22 Selma Calmes, M.D. is an individual retained by the Coroner’s Office as an  
23 outside consultant with the title of Deputy Medical Examiner (“Calmes”). She is  
24 being sued in her individual capacity.

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1           13. Plaintiff is informed and believes and thereon alleges that Defendant  
2 John Kades, is an individual employed by the County of Los Angeles as a Deputy  
3 Coroner, with the rank of Captain within the Investigations Division of the  
4 Department of the Coroner ("Kades"). He is being sued in his individual capacity.

5           14. Plaintiff is informed and believes and thereon alleges that Defendant  
6 Ed Winter, is an individual employed by the County of Los Angeles as the  
7 Assistant Chief Investigator, Operations Bureau, of the Department of the Coroner  
8 ("Winter"). He is being sued in his individual capacity.

9           15. Plaintiff is uncertain as to the identity or capacity of the other  
10 Defendants included herein as DOES 1 through 10, inclusive, and therefore sues  
11 these Defendants by fictitious names. Plaintiff is informed and believes and  
12 thereon alleges that said Defendants, DOES 1 through 10, inclusive, and each of  
13 these, are liable to Plaintiff on the facts herein alleged and will seek leave of this  
14 Court to amend this Complaint when true names are ascertained.

15           16. Plaintiff is informed and believes and thereon alleges that, at all times  
16 herein mentioned, each of these Defendants was an agent, or employee of each of  
17 the other co-Defendants and, in doing the things herein alleged, was acting in the  
18 scope of his or her authority as such agent with the permission and consent of each  
19 of the other co-Defendants.

20           17. Plaintiff is informed and believes, and thereon alleges, that, at all  
21 times herein mentioned, each of the Defendants was the agent and/or employee  
22 and/or co-conspirator of each of the remaining Defendants, and in doing the things  
23 hereinafter alleged, was acting within the scope of such agency, employment  
24 and/or conspiracy, and with the permission and consent of other co-Defendants.

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1 All acts alleged herein are alleged as part of a conspiracy to violate Plaintiff's  
2 rights.

3 **JURISDICTION, VENUE AND DIVISION ASSIGNMENT**

4 18. The jurisdiction of this court over the subject matter of this action is  
5 predicated upon 28 U.S.C. §§ 1331 and 1343.

6 19. Venue is proper under 28 U.S.C. §1391(b)(2), and assignment to the  
7 Western Division of this Court is proper, because a substantial part of the events  
8 or omissions giving rise to the claims herein occurred in Los Angeles County,  
9 California.

10 20. Plaintiff's federal claims arise under the United States Constitution,  
11 in particular the First, Fourth, Fifth, and the Fourteenth Amendments. In addition,  
12 Plaintiff's federal claims arise under federal law including, but not limited to, the  
13 federal Civil Rights Act, *Title 42, United States Code §§ 1983*. The acts and  
14 omissions of Defendants and others, as alleged herein, were committed by  
15 Defendants and others, and each of them, under color and pretense of the  
16 Constitution, statutes, ordinances, rules, regulations, practices, customs, patterns,  
17 and usages of the State of California and/or of the counties referenced herein.  
18 Supplemental jurisdiction for the state claims is appropriate pursuant to 28 U.S.C.  
19 § 1367(b).

20 **OVERVIEW OF RELIEF SOUGHT**

21 21. Valley Surgical Center, LLC ("Valley") seeks injunctive relief and  
22 damages against the Coroner's Office, its agents and employees and outside  
23 retained consultants, including but not limited to Dr. Lakshmanan  
24 Sathyavagiswaran, Dr. Adrian Marinovich, Dr. Raffi Djabourian, Dr. Denis C.  
25 Astarita, Dr. Selma Calmes, and Ed Winter restraining them from having further  
26

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1 participation in the death investigation of Paula Rojeski. In this 19 month  
2 investigation, the Coroner's Office and its agents have engaged in reckless and  
3 illegal conduct by drafting and disseminating a false autopsy report concerning the  
4 death of Paula Rojeski.

5 22. The Defendants' conduct violated Plaintiff's rights under the First,  
6 Fourth, Fifth and Fourteenth Amendments (and their California analogues) –  
7 including depriving them of the following statutes:

- 8 a. Violate its due process right to a governmental investigation not  
9 based on false and/or fabricated evidence;
- 10 b. Violate its due process right to an unbiased governmental  
11 investigation not based on false and/or fabricated evidence;
- 12 c. Violate its due process right not to have exculpatory evidence  
13 destroyed in bad faith;
- 14 d. Violate its First Amendment and due process rights to petition the  
15 government and to have access to the courts;
- 16 e. Violate its First Amendment rights to engage in lawful speech  
17 without being retaliated against for doing so;
- 18 f. Violate its First Amendment rights to engage in lawful speech  
19 without having its right to do so infringed upon and chilled by the  
20 actions of governmental agents or employees;
- 21 g. Violate its due process rights to petition the government and to  
22 have access to the courts;
- 23 h. Violate its Fourth Amendment right not to be subjected to an  
24 unlawful search and seizure;
- 25 i. Violate its equal protection and/or due process right not to be  
26 singled out for irrational and/or arbitrary discriminatory treatment.

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23. Defendants' conduct also violated, *inter alia*, (1) Cal. Gov't Code § 27491.4 (coroner must act in accordance with medico-legal practice); (2) Cal. Gov't Code § 27491.5 (coroner's report must be in accordance with facts ascertained from inquiry, autopsy and other scientific findings); (3) Cal. Gov't Code § 27491.45 and Cal. Health & Safety Code § 7151.2 (regarding appropriate organ harvesting); (4) Civil Code § 815.6 (violation of mandatory duty), and (5) Cal. Civil Code § 52.1 (use of threats, intimidation or coercion to interfere and attempt to interfere with exercise of rights secured by Federal or State Constitution or law.

### The Bariatric Surgery and the Failure by the Coroner to Preserve Evidence

24. On September 8, 2011, Paula Rojeski, a 55 year old female, underwent laparoscopic surgery at Valley Surgical Center for placement of an adjustable gastric band to treat her longstanding obesity. As demonstrated by the Anesthesia Record from the Rojeski surgery contained in the Figures below, the surgery lasted for 30 minutes, with a start time of 9:15 a.m. and a finish time of 9:45 a.m. When the attending surgeon closed the patient, there were no indications of bleeding or complications.

**Anesthesia Record**

Procedure Lap Band Date 9/8/11 Allergies NYDA ✓

OR TIMES		TYPE OF ANESTHESIA:	
START	FINISH	GENERAL:	REGIONAL:
ANESTH <u>8:55</u>	ANESTH <u>11:15</u>	<input checked="" type="checkbox"/> Intravenous <input type="checkbox"/> Inhalation	<input type="checkbox"/> Spinal <input type="checkbox"/> Epidural
OP <u>9:15</u>	OP <u>9:45</u>	<input type="checkbox"/> Mask O <sub>2</sub> <input type="checkbox"/> Oral/Nasal Airway	<input type="checkbox"/> Auxiliary <input type="checkbox"/> Block
<input type="checkbox"/> Patient Identified <input type="checkbox"/> Chart Reviewed <input type="checkbox"/> Consent signed <input type="checkbox"/> NPO Since <u>AM</u> AM/PM <input type="checkbox"/> Time Out Conducted <input type="checkbox"/> Pneumatic Comp to LE		PREANESTHETIC VITAL SIGNS: BP: <u>141/90</u> HR: <u>84</u> R: <u>16</u> Temp: <u>36.8</u> O <sub>2</sub> SAT: <u>98</u>	

**OPERATING ROOM RECORD**

Age: 55 Sex: F Allergies: NYDA

Type of Anesthesia: ☒ General ☐ MAC ☐ Local ☐ Spinal ☐ Epidural ☐ Block

Patient in Room	Anesthesia Start	Anesthesia End	Surgery Start	Surgery End
<u>0855</u>	<u>0855</u>	<u>1115</u>	<u>0915</u>	<u>0945</u>

Surgeon: GEE  
 Anesthesia Provider: Chinn

Assistant: Chinn  
 AND INJUNCTIVE RELIEF

25. From 9:45 a.m. until approximately 10:55 a.m., the patient recovered from the anesthesia.<sup>1</sup> The anesthesiologist was available and continued to monitor the patient after the surgery ended. (The anesthesiologist remained by the patient's side and continued to observe the patient until 11:15 a.m. which is the reason that the Operating Room Record reflects that the anesthesiologist ended his monitoring at 11:15 and the patient was turned over to LA City Firemen for transport to the hospital). At 10:55 a.m., the patient suffered PEA (pulseless electrical activity) and cardiac arrest. The surgeon at Valley Surgical Center initiated CPR and promptly called 911.

26. LA City Firemen responded and initiated their own vigorous CPR on the deceased. The significant resuscitative trauma and injuries included anterolateral fractures of the left rib 3, and right ribs 2, 3, 4, 5, 6, and 7. There were also resuscitative injuries resulting in abrasions of the midline anterior chest.

27. Prior to the initiation of resuscitation, there was no blood coming from the laparoscopic incisions. However, following the resuscitation efforts from LA City Firemen, which broke her ribs, damaged her lungs, and caused hemorrhage into the mediastinum, the LA City Firemen also observed blood coming from the laparoscopic incisions. The firemen then transported the patient to West Hills Medical Center at 11:15 a.m., where the patient was pronounced dead at 11:41 a.m.

28. The Coroner's Office was informed of the death at 12:17 p.m. on September 8, 2011, and the case was accepted by Coroner's Representative Hiath with the Coroner's Reference No. 2011 1-05916.

---

<sup>1</sup> The anesthesiologist stayed with the patient, which is why the records show 11:15 a.m. for the "Anesthesia End" time. However, the administration of anesthesia ceased at 9:45 a.m. the same time as the conclusion of the surgery.

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1        29. Following the patient's death, there was extensive post-mortem tissue  
 2 and bone procurement by OneLegacy, Inc. ("OneLegacy"), a tissue procurement  
 3 company. The deceased's sister, Michele Pelter, gave authorization over the phone  
 4 to OneLegacy, Inc. to harvest the heart, skin, and bones from the deceased. The  
 5 authorization was given at 7:55 a.m. on September 9, 2011, the day following the  
 6 surgery, but prior to the autopsy. Unfortunately, the Coroner did nothing to  
 7 prevent the deceased's organs from being harvested, which interfered with the  
 8 death investigation by failing to preserve exculpatory evidence, the value of which  
 9 was known at the time. The Coroner did not even observe the harvesting.

10        30. On September 12, 2011, the Los Angeles County Coroner's Office  
 11 conducted an autopsy of Ms. Rojeski's body. The Coroner's Report states that  
 12 "skin and bones, legs, arms, and back" were harvested from the patient's body  
 13 before the autopsy. The organ procurement was so extensive that the pathologist  
 14 wrote in the Coroner's Report, "Rigor mortis cannot be assessed due to prior organ  
 15 procurement." See Coroner's Rojeski Final Report, attached hereto as Exhibit  
 16 "6."

17        31. The Coroner's Office knew that the deceased had suffered from PEA  
 18 (pulseless electrical activity) which is frequently caused from a pulmonary  
 19 embolism resulting from dislodging of blood clots from the lower extremities.  
 20 When the paramedics arrived to transport Ms. Rojeski to the hospital, they knew  
 21 about her PEA condition and her medical records accompanied her to the hospital.  
 22 Indeed, the Hospital Emergency Room report and the report from the harvesting  
 23 company all confirm Ms. Rojeski's PEA condition.

24        32. Despite this knowledge, the Coroner's Office allowed OneLegacy  
 25 organ procurement, without supervision, to extensively harvest bones from the  
 26 lower extremities prior to autopsy destroying any opportunity of discovering

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1 possible blood clots in the lower extremities which may have led to a pulmonary  
 2 embolism. Such exculpatory evidence, was consciously and recklessly  
 3 disregarded by the Coroner's Office by its allowing OneLegacy to harvest  
 4 Rojeski's body for organs and tissue without significant limitations. Such  
 5 evidence, which is now destroyed, cannot be obtained by other means. Therefore  
 6 the Coroner should have denied harvesting of tissue from the lower extremities.  
 7 Further, the Coroner should have also denied harvesting of the heart and lungs as  
 8 well, but did not.

9 33. Instead, the Coroner's Office did not observe the harvesting of the  
 10 tissues and bones or substantially or significantly limit in any way the harvesting  
 11 procedure. Nor did the Coroner's Office limit in any way the alteration and  
 12 disruption of the deceased's body, which interfered with the investigation, from  
 13 the skin and bones from the harvesting, as mandated by *California Health &*  
 14 *Safety Code § 7151.2* and *Cal. Gov't Code §27491.45*. The Coroner's Office  
 15 merely requested that OneLegacy's "recovery avoids operations site."

16 34. Following the completion of the autopsy, the Coroner's office also  
 17 failed to embalm the body of the deceased, despite having the statutory authority  
 18 to do so under *Cal. Gov't. §27471*. Thus, the Coroner's Office allowed  
 19 destruction of the heart valves which it incorrectly interpreted as normal at  
 20 autopsy. As ample evidence shows, Ms. Rojeski had calcification of the heart  
 21 valves and moderate aortic regurgitation as evidenced by radiographic imaging.  
 22 Again the value of this exculpatory evidence was known at the time of destruction  
 23 of evidence. Rather than embalm the body and protect evidence which could not  
 24 be recovered by other means in this case where the cause of death was unknown,  
 25 the Coroner's Office instead chose to do a shoddy autopsy which missed the  
 26

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 AND INJUNCTIVE RELIEF

1 significant fact that the heart valves were damaged and allowed burial with  
2 decomposition of the body.

3 35. Any attempt to exhume Mrs. Rojeski's body for a re-examination  
4 would be utterly useless, thereby permanently depriving Valley of this evidence.  
5 Such spoliation of evidence, owing to the unsupervised tissue harvesting, and  
6 failure to embalm the body, constitutes multiple violations of law enforcement's  
7 duty to preserve evidence that might be expected to be exculpatory, as well as play  
8 a significant role in any investigation.

9 36. The value of this evidence was known at the time of its destruction as  
10 being essential to Valley and its medical staff regarding any cause of death or  
11 criminal investigation. The failure to collect and preserve such evidence  
12 materially affects the possibility of homicide charging recommendations and/or  
13 decisions. The failure to collect and preserve evidence substantially affects the  
14 Coroner's recommendations for further disciplinary action by the California  
15 Medical Board against Valley and its medical staff, and it significantly affected  
16 the outcome of the Rojeski Final Report, which the Coroner seeks to release.

17 37. Prejudice to Plaintiff has accrued from the foregoing failure to  
18 preserve evidence as that evidence would have further confirmed that Plaintiff's  
19 explanation of the circumstances of death are correct and would have further  
20 undermined any suggestion that the death qualifies as a homicide or was the result  
21 of gross negligence by Valley. It is especially prejudicial to Valley because the  
22 Coroner's Office refuses to rule out homicide as the cause of death, and also  
23 recommends that Valley and two members of its medical staff be referred to the  
24 California Medical Board for disciplinary proceedings.

25 ///

26 ///

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1        **The Anonymous Letter and Illegal Search of Valley Surgical Center**

2        38. On October 17, 2011, the Coroner's Office received an "anonymous  
3 letter" from an individual claiming that during the September 8, 2011 surgery: (1)  
4 oxygen tanks were empty, (2) fluids leaked on the floor, (3) the anesthesiologist  
5 recorded false information, (4) the monitoring equipment was broken, and (5) the  
6 times of the cardiac arrest were falsified<sup>2</sup> (the "Anonymous Letter").

7        39. In late November, the Coroner's Office announced that it wanted to  
8 inspect the premises of Valley and in particular inspect Valley's anesthesia  
9 equipment and other medical equipment. Valley then learned that the Coroner's  
10 Office had retained Selma Calmes, M.D., as its Anesthesia Consultant for the  
11 Rojeski case and that she would be accompanying the Coroner's team to the  
12 inspection of Valley's facilities.

13        40. On or about December 1, 2011, prior to the Coroner's site inspection,  
14 Valley's counsel, Robert Silverman, sent a letter to the Coroner's Office protesting  
15 Dr. Calmes as the Consulting Anesthesiologist for the Rojeski investigation. *See*  
16 *December 1, 2011 letter from Robert Silverman to Coroner's Office, attached*  
17 *hereto as Exhibit "1."* The letter noted that Dr. Calmes had a publicly  
18 documented professional bias against ambulatory surgery centers. *See Id.* Dr.  
19 Calmes publicly stated in a previous autopsy report issued by the Coroner's Office  
20 in January 2011 that she considered any ambulatory outpatient facility to be an  
21 inappropriate platform for gastric banding procedures for patients with sleep  
22

23        <sup>2</sup> Nevertheless, nowhere in the Rojeski Final Report was there any verification of any of  
24 these allegations. In fact, Valley refuted all of the allegations in the Anonymous Letter as  
25 Valley provided full and complete surgical logs, medical records, and equipment  
26 maintenance logs to the Coroner's Office which disproved most, if not all, of the  
allegations in the Anonymous Letter.

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1 apnea. *See Exhibit "1" attached hereto and incorporated herein.*<sup>3</sup> Despite her  
 2 obvious bias, the Coroner's Office refused to utilize a different anesthesiology  
 3 consultant and insisted that the inspection would go forward with Dr. Calmes in  
 4 attendance. *See December 2, 2011 letter from County Counsel to Robert*  
 5 *Silverman attached hereto and incorporated herein as Exhibit "2."*

6 41. Notwithstanding the foregoing, the Coroner's Office issued an illegal  
 7 Administrative Subpoena on December 5, 2011 signed by John Kades, Deputy  
 8 Coroner, which improperly demanded that Valley consent to a search of its  
 9 premises and equipment. *See Exhibit "3"*. The Administrative Subpoena was  
 10 issued without any judicial adjudication or judicial review and thus was illegal on  
 11 its face in terms of compelling a search of Valley's premises by Dr. Calmes,

12 42. The Coroner's Office appeared on December 5, 2011 at Valley's  
 13 facilities with this unauthorized and unlawful subpoena compelling Valley to  
 14 allow the Coroner's Office and "its duly appointed deputies" to access the  
 15 anesthesia equipment used on Ms. Rojeski.

16 43. The Coroner's Office admitted at the time of the inspection that they  
 17 issued the subpoena solely to compel Valley to allow Dr. Calmes onto the  
 18 premises.<sup>4</sup> *See Exhibit "3" attached hereto and incorporated herein.*

19  
 20  
 21 <sup>3</sup> In that January 2011 autopsy report, Dr. Calmes cites to outdated guidelines issued by  
 22 the American Society of Anesthesiologists in 2006. The overwhelming majority of  
 23 scientific literature published since 2006 on this topic approves and endorses gastric  
 24 banding procedures in an outpatient setting. Thus, Dr. Calmes not only had a publicly  
 25 documented bias against Valley, but had relied on outdated scientific data to support her  
 26 biased position. *See Exhibit "2" attached hereto and incorporated herein.* This fact was  
 27 called to the Coroner's attention in a March 2011 letter from Valley's attorney, Robert  
 Silverman, to the Coroner in March 2011.

<sup>4</sup> The issuance of an administrative subpoena to compel a "search" is illegal.

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1        44. Because of the close nexus in time between Valley protesting Dr.  
 2 Calmes appointment to the Rojeski investigation on December 1, 2011, and the  
 3 issuance of the illegal Administrative Subpoena on December 5, 2011 compelling  
 4 Valley, under threat of criminal contempt prosecution, to allow Dr. Calmes onto  
 5 its premises, Plaintiff alleges, on information and belief, that this action was in  
 6 retaliation for Valley's lawful exercise of its First Amendment right to petition the  
 7 government and object to Dr. Calmes' participation, and that Valley's prior  
 8 complaint regarding Dr. Calmes was a motivating factor in unlawfully presenting  
 9 the administrative subpoena to search Valley's premises.

10        45. At the inspection, Valley Surgical showed the Coroner's  
 11 representatives its records demonstrating the Anonymous Letter was false:

- 12        a. there had been no defect in the equipment;
- 13        b. the oxygen system functioned correctly at the time of surgery;
- 14        c. the equipment had been serviced only 10 days earlier without  
 15 incident, and;
- 16        d. two surgeries took place at the facility in the same operating room  
 17 only 45 minutes after the Rojeski surgery without incident,  
 18 utilizing the same equipment and oxygen system.

19        **The Coroner's Office Breached its Own Security Hold on the**  
 20 **Investigation**

21        46. For the next four months, Valley heard nothing from the Coroner's  
 22 Office. Whenever Valley asked about the status of the investigation, the Coroner's  
 23 Office replied that there was a "Security Hold" on the investigation, and nothing  
 24 could be released or discussed until the investigation was completed.

25        47. During the same four months, Valley discovered that an ex-employee  
 26 had filed a "whistleblower" lawsuit against Valley, in which the whistleblower

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1 admitted to having made a written complaint to the Coroner's Office regarding the  
 2 circumstances of Rojeski's death. Valley responded not only to the complaint, but  
 3 also provided the Coroner's Office with information that refuted and disproved the  
 4 allegations in the Whistleblower complaint and the Whistleblower's subsequent  
 5 amended complaint. In the amended complaint, the plaintiff/Whistleblower  
 6 significantly and substantially changed and revised the allegations concerning  
 7 Rojeski's death. Valley requested the opportunity to discuss the alleged  
 8 complaints with the Coroner's Office. However, the Coroner's Office, again,  
 9 declined to meet with Valley's representatives replying that there was a "Security  
 10 Hold" on the investigation, and nothing could be discussed until the investigation  
 11 was completed.

12 48. Then on or about April 6, 2012, several major news outlets, including  
 13 the Los Angeles Times and the Orange County Register published a story that the  
 14 Coroner's Office had referred the Rojeski investigation to the Los Angeles Police  
 15 Department Robbery-Homicide Division. Thus, despite the Coroner's "Security  
 16 Hold" on the investigation, the Coroner leaked its LAPD investigative referral to  
 17 the news media. Valley's counsel spoke with Detective Dan Myers of the LAPD  
 18 Robbery-Homicide division, who confirmed the Coroner's Office referral and that  
 19 the Coroner's Office had not forwarded to the LAPD Valley's two letters which  
 20 showed that the allegations regarding the death of Rojeski in both versions of the  
 21 Whistleblower complaint were false. This was in violation of the Coroner's legal  
 22 directive in Government Code § 27491.1, which states that the Coroner's report to  
 23 law enforcement must include "information received by the Coroner relating to the  
 24 death."

25 49. Despite an active investigation and a Security Hold on the  
 26 investigation, Plaintiff Valley is informed and believes and thereon alleges that

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1 Defendant Calmes breached the Security Hold during an active investigation when  
 2 she gave a presentation on September 21, 2012 titled "Ambulatory Surgery  
 3 Disasters" at Hotel Nikko in San Francisco. Calmes, appearing under the title of  
 4 "Los Angeles County Coroner/Medical Examiner," violated the Coroner's  
 5 Security Hold by discussing two Lap Band deaths where she was the appointed  
 6 Anesthesia Consultant to the Coroner's Office.

7 50. Her charts and slides intentionally and openly criticized surgery  
 8 centers working with 1 800 GET THIN, which include Plaintiff Valley. She  
 9 violated the Coroner's Security Hold on the Rojas investigation by intentionally  
 10 disclosing unconfirmed information regarding the Rojas death and repeating her  
 11 discredited professional opinions regarding bariatric surgeries in ambulatory  
 12 surgery centers. In fact, she even put up a billboard of 1 800 GET THIN's  
 13 advertising in her speech and related that there were two related Lap Band deaths.  
 14 Obviously, one of those two deaths was the death of Paula Rojas, and as of  
 15 September 2012, this matter was still under investigation and the Coroner's  
 16 Security Hold. *See Exhibit "5."*

17 51. Approximately two weeks before that speech, Valley submitted a  
 18 written letter with medical records to the Coroner's Office demonstrating how  
 19 Paula Rojas had a prior, undisclosed history of prescription weight loss  
 20 medication use, including Fen-Phen and that she had admitted in court documents  
 21 to having suffered significant cardiac damage. *See Exhibit "4" attached hereto.*  
 22 Valley's presentation of this evidence to the Coroner's Office called into the  
 23 question the entire methodology of the Rojas investigation in general with lack  
 24 of any investigation into her past medical history. The close nexus in time between  
 25 Valley's September 8<sup>th</sup> letter to the Coroner's Office and Defendant Calmes  
 26 speech, in her official capacity as Deputy Medical Examiner for the Coroner's

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Office, suggests that the later action was partly in retaliation for Valley's exercise of its First Amendment rights, and Valley so alleges on information and belief.

**Plaintiff Valley Conducts Its Own Investigation into Paula Rojeski**

52. In September, 2012, Paula Rojeski's estate filed a wrongful death action against Valley and its medical staff. By this time, the Coroner's Investigation had been pending for 12 months without any report or indication when a report would be issued.

53. Valley uncovered a series of medical records which showed Ms. Rojeski had a severely compromised, but undisclosed heart condition from her use of Fen-Phen and other weight loss medications during the years 2001-2002, and again during 2009-2010. In addition, Valley uncovered documents showing that Ms. Rojeski was a lead plaintiff in a civil lawsuit against the makers of Fen-Phen where she admitted to having suffered severe cardiac damage from Fen-Phen usage. *See Exhibit "4" attached hereto and incorporated herein.*

54. Not less than ten times in statements to Valley Medical personnel, the deceased stated she had no prior heart damage when in fact she had filed a lawsuit in 2003 entitled *Paula Rojeski v. Wyeth, et. al.*, Orange County Superior court Case No. 03CC00687, claiming severe heart injury from her use of Fen Phen in 2001 and 2002. Ms. Rojeski also concealed from Valley Medical personnel that she commenced taking the prescription weight loss medication, Phentermine, in 2009. *See Exhibit "16" attached hereto and incorporated herein.* In fact, she obtained the Phentermine in 2009, from the same physician from whom she had obtained the Fen Phen in 2002. *Id.*

55. Ms. Rojeski also concealed that she had gone to the emergency room at Saddleback Medical Center in Lake Forest, California, on August 11, 2011, which was only 28 days prior to her September 8, 2011 surgery, with malignant

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1 blood pressure of 205/150, radiating pain in her neck and shoulders, heart  
 2 palpitations, and an abnormal EKG. *See Exhibit "15" attached hereto and*  
 3 *incorporated herein.*

4 56. Valley provided these previously undisclosed and concealed records  
 5 to the Coroner's Office in Fall 2012, several months before the Rojeski Final  
 6 Report was completed.

7 57. With her weakened heart from the prior Fen-Phen usage, Ms. Rojeski  
 8 was not a good candidate for laparoscopic surgery because she had a compromised  
 9 heart, and could not sustain events during surgery which would not have affected a  
 10 healthy patient. *See Declaration and expert report attached thereto of Dr. Terry*  
 11 *Simpson, attached hereto as Exhibit "10".* Dr. Simpson's report states that Ms.  
 12 Rojeski likely died after surgery because of her undisclosed injury.

13 58. All of this uncovered information, which had been concealed from  
 14 Valley and its medical staff by Ms. Rojeski, was addressed and documented in a  
 15 series of letters to the Coroner's Office. The letters were dated September 7, 2012,  
 16 October 3, 2012, October 8, 2012, October 25, 2012, November 6, 2012,  
 17 November 13, 2012, November 16, 2012, November 21, 2012, December 6, 2012,  
 18 and December 10, 2012. The letters contained more than 1,000 pages of Paula  
 Rojeski's medical records, and other relevant documents.

19 **Valley Surgical's Review of the Coroner's Report.**

20 59. While sending the various letters, Valley repeatedly asked to meet  
 21 with the Coroner's Office to review the evidence that Valley had presented  
 22 regarding Ms. Rojeski. The Coroner's Office, claiming that there was a Security  
 23 Hold on the investigation, rebuffed Valley's requests.

24 60. In January 2013, Valley's Counsel, Centurion, heard through legal  
 25 representatives of Ms. Rojeski's estate that the Coroner had shared the findings of  
 26

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1 its autopsy report concerning Ms. Rojeski's death (the "Rojeski Final Report")  
2 with representatives of Ms. Rojeski's estate. Valley then immediately renewed its  
3 demand for a meeting with the Coroner's Office.

4 61. On January 15, 2013, more than 16 months following the deceased's  
5 death, the Coroner's Office met with Valley's representatives. After admitting to  
6 having revealed the contents of the Rojeski Final Report to Rojeski's estate  
7 representative, the Coroner's Assistant Chief Investigator, Ed Winter, agreed to  
8 release a copy of the Rojeski Final Report to Valley's legal counsel who were in  
9 attendance. *See Exhibit "6," to be filed under seal separately from this*  
10 *Complaint.*

11 62. The Coroner's representatives stated that Valley had one week in  
12 which to review the Rojeski Final Report. However, Ed Winter emphasized that  
13 the Rojeski Final Report would not be modified or revised. He stated that, at best,  
14 the Coroner's Office might issue a supplemental report.

15 63. At the conclusion of the meeting, Investigator Winter stated that the  
16 Rojeski Final Report was being released to Valley's legal counsel under an  
17 understanding of confidentiality. Winter further elaborated by saying that, if  
18 anyone from Valley released or disclosed the Rojeski Final Report to any third  
19 party, that the Coroner's Office would then immediately release and distribute the  
20 Rojeski Final Report to the public. Defendant Winter additionally stated "I don't  
21 want to hear about this in any report from any source." Winter's statements were  
22 reasonably interpreted by Valley and its legal representatives as a threat and  
23 intimidation against Valley presenting any complaints about the Coroner's  
24 investigation or any complaints about the Rojeski Final Autopsy Report to any  
25 government agency or judicial forum outside of the Coroner's Office. As a result,  
26 Valley has felt constrained from filing complaints regarding the Coroner's

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Office's violations of its rights, including filing administrative tort claims under Govt. Code § 910.<sup>5</sup>

64. The Rojeski Final Report stated the mode of death for the deceased was "undetermined." (*Exhibit "6," to be filed separately under seal*). More specifically:

- a. the Coroner's Office could not rule out that the death was a homicide;
- b. the Coroner's Office found the attending Anesthesiologist, Dr. Demming Chau, and the attending Surgeon, Dr. Julius Gee, were grossly negligent and that they both should be referred over for further disciplinary proceedings by the California Medical Board;
- c. the Coroner's Office found (without any factual substantiation) that Valley did not comport itself within the bounds of the standards of due care.

65. The Rojeski Final Report contains a separate opinion by Dr. Selma Calmes, who was retained as a Consulting Anesthesiologist by the Coroner's Office. Her factual findings erroneously declare on page 2 starting at line 5: "The inhalation anesthetic isoflurane was stopped at 0945, and circuit gas flow was increased, to remove isoflurane from the system. **No further anesthetic drugs appear to have been given for the remaining 1 1/2 hrs of surgery**, on review of the anesthesia record." (Emphasis added).

---

<sup>5</sup> Valley's legal representatives have only shown the report to the seven retained experts for purposes of refuting the conclusions contained in the Rojeski Final Report of gross negligence and sub-standard care. However, Valley's legal representatives have refrained from filing any public complaint regarding Valley's allegations of violations of its rights by the Coroner's Office as Valley has feared, and continues to fear, that the Coroner's Office would retaliate by officially releasing the Rojeski Final Report in its current form with all of its false findings and conclusions.

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66. To the contrary, the medical and surgical records clearly state that the surgery ended at 9:45 a.m., the same time the anesthesia was stopped. There was no "remaining 1-1/2 hours of surgery" without anesthesia. Calmes thus erroneously claims that the patient was therefore awake during the last hour of her surgery, though paralyzed while bleeding to death with the surgeon standing there. This is erroneous because the patient was closed up at 9:45 a.m. and then placed in recovery and thus there was no need to be administering any more anesthesia. The surgeon had completed his task and closed up Ms. Rojeski approximately 75 minutes before she went into cardiac arrest.

67. Dr. Calmes complained that she was unable to read the records and that "The hand-written anesthesia record is nearly unreadable, even using a magnifying glass." However, the records supplied to the LA Coroner's Office were in no manner illegible and are reproduced in sufficient clarity as shown below.

**FIGURE 1**

**Anesthesia Record**

Procedure Leap Band Date 9/8/11 Allergies MRSA ✓

<b>OR TIMES</b>		<b>OR TIMES</b>		<b>OR TIMES</b>	
START	FINISH	START	FINISH	START	FINISH
ANESTH <u>8:55</u>	ANESTH <u>11:15</u>	OP <u>9:15</u>	OP <u>9:45</u>		
<input checked="" type="checkbox"/> Patient Identified <input checked="" type="checkbox"/> Chart Reviewed <input checked="" type="checkbox"/> Consent signed <input checked="" type="checkbox"/> NPO Since <u>7:00</u> AM/PM <input checked="" type="checkbox"/> Time Out Conducted <input checked="" type="checkbox"/> Pneumatic Comp to LE		<b>TYPE OF ANESTHESIA:</b> GENERAL: <input checked="" type="checkbox"/> Intravenous <input type="checkbox"/> Inhalation MAC: <input checked="" type="checkbox"/> Nasal O <sub>2</sub> <input type="checkbox"/> Mask O <sub>2</sub> REGIONAL: <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Oral/Nasal Airway <input type="checkbox"/> Axillary <input type="checkbox"/> Bier Block			
Patient Safety: <input checked="" type="checkbox"/> Anesthesia Machine Checked <input checked="" type="checkbox"/> Safety Belt On <input checked="" type="checkbox"/> Pressure Points Checked and Padded <input checked="" type="checkbox"/> Arms Tucked <input checked="" type="checkbox"/> Axillary Roll <input checked="" type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Draped <input type="checkbox"/> Goggles <input type="checkbox"/> Pads		<b>PREANESTHETIC VITAL SIGNS:</b> BP: <u>141/92</u> HR: <u>89</u> Temp: <u>97.8</u> O <sub>2</sub> SAT: <u>98%</u>			
<b>Eye Care:</b> <input checked="" type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Draped <input type="checkbox"/> Goggles <input type="checkbox"/> Pads		<b>ANESTHESIA PROVIDER:</b> <u>Dorothy Chan MD</u> Signature <u>Chan MD</u>			
<b>ASA PS</b> I II III IV V E <u>pt is dry (dehydrated) pre-op before op.</u> X		<b>SURGEON:</b> <u>Dr. Greer</u>			
<b>AGENTS</b> <u>Propofol</u>		<b>PREANESTHETIC STATE:</b> <input checked="" type="checkbox"/> Calm <input type="checkbox"/> Apprehensive			

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68. The records unquestionably indicate the times of the surgery and anesthesiologist's supervision which the Coroner's Consultant has ignored. Instead, the Consultant fabricated and falsified facts that were patently contradicted by the medical records. Moreover, if the records were so illegible, then Dr. Calmes and the rest of the authors of the Rojeski Final Report should never have been so adamant and confident in their findings and conclusions.

69. The Anesthesia Record unambiguously specifies the start time of the surgery as 9:15 a.m. and end time of the surgery as 9:45 a.m., and the writing is both clear and legible in direct contravention of the claim from the consultant.

70. The Operating Room Record completed by the nurse also clearly specifies the start and end time of surgery:

## FIGURE 2

**OPERATING ROOM RECORD**

Age: 55 Sex: F Allergies: NADA

Type of Anesthesia: ☒ General ☐ MAC ☐ Local ☐ Spinal ☐ Epidural ☐ Block

Patient in Room	Anesthesia Start	Anesthesia End	Surgery Start	Surgery End
<u>0855</u>	<u>0855</u>	<u>1115</u>	<u>0915</u>	<u>0945</u>

Surgeon: GEE Anesthesia Provider: Plambeck, P.A.C. Assistant: CLINW

Given the unambiguous medical records, the factual findings from the Anesthesia Consult cannot be supported.

71. Dr. Calmes states in her portion of the Rojeski Final Report:

"If there was cerebral perfusion during this time (we can anticipate that cerebral flow was present for at least some part of the next 1 1/2 hrs even though she was in a steep head-up position, which works against adequate cerebral blood flow when BP is low), **she had to be feeling pain and was conscious but paralyzed as she probably bled to death.**

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72. Dr. Calmes, without any justification or confirmation whatsoever, and, with complete disregard for the medical records and surgical logs, goes on to say:

“Strangely the anesthesiologist realized the patient could not tolerate the anesthetic agent (it was turned off at 0945) but told the surgeon all was well. This patient was probably awake and feeling pain as she proceeded along the path to her death over the next 1 ½ hours.” (Emphasis added).

73. However, the undisputed medical records, as shown from the excerpts above in Figures 1 and 2 clearly demonstrate (1) anesthesia was initiated at 8:55 a.m. (2) surgery commenced at 9:15 a.m. and (3) surgery ended at 9:45 a.m. The patient was not awake and paralyzed for 1 ½ hours of surgery, feeling pain and bleeding to death as Calmes falsely and outrageously proclaims. There is no evidentiary basis for these false statements in the Final Autopsy Report. This reckless conduct was done as part of Coroner’s Office’s concerted effort to harm Valley by instilling terror and outrage in anyone reading the report.

**Other Medical Examiners Blindly Adopt Dr. Calmes’ Erroneous Findings**

74. The Coroner’s pathologists performing the autopsy, Dr. Adrian Marinovich and Dr. Raffi Djabourian, state at page 12-13 of their Report:

“The anesthesiology consultant report indicates that there was gross negligence on the part of the anesthesiologist, in that he failed to meet basic standards of anesthesia care, in particular: failure to adequately assess the patient’s condition during surgery, to communicate the patient’s deteriorating condition to the surgeon, **and to provide pain relief and amnesia while the patient was paralyzed during surgery.**” (Emphasis added).

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1        75. Thus, the pathologists assigned to the Rojeski investigation decided  
 2 to blindly rely upon and entirely premise their own allegedly independent findings  
 3 and conclusions on Dr. Calmes' false factual statements and inaccurate  
 4 conclusions.

5        76. The repeating of the erroneous findings and conclusions by Dr.  
 6 Calmes was continued by others within the Coroner's Office who were assigned to  
 7 investigate the Rojeski matter. The portion of the Rojeski Final Report authored  
 8 by Drs. Marinovich and Djabourian states:

9        "Certifying the manner of death as homicide vs. accident would require  
 10 knowledge of whether or not this death resulted from a conscious disregard  
 11 for the patient's safety. The currently available information does not allow  
 12 for a conclusion that the surgeon or anesthesiologist intentionally  
 13 disregarded the patient's safety. The manner of death thus could not be  
 14 determined."

15        77. The statement is internally inconsistent and illogical. Since there is  
 16 no evidence of intentional disregard of the patient's safety or any "knowledge"  
 17 that would indicate a homicide, the only possible explanation for the patient's  
 18 death is that it was an accident.

19        78. The Surgical Consultant retained by the Coroner's Office for the  
 20 Rojeski Final Report, Dr. Denis Astarita, states "the likely manner of Death will be  
 21 Accident." To ignore this obvious fact and classify this death as "undetermined"  
 22 ignores the admitted facts in the statement above. The Coroner's Office exhibits  
 23 bad faith by avoiding the obvious appropriate conclusion that the manner of death  
 24 was an accident.

25        79. The findings from Drs. Marinovich and Djabourian are also based on  
 26 the receipt by the Coroner's Office of the Anonymous Letter which the Anesthesia  
 27

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1 Consult recites in detail and leads the Coroner's Office to conclude there was  
2 gross negligence committed by Valley's medical staff.

3 80. Furthermore, on the basis of the gross negligence conclusion, the  
4 Rojeski Final Report calls for referral of Valley's medical staff over to the  
5 California Medical Board for further disciplinary proceedings. This conclusion of  
6 gross negligence and the call for further disciplinary proceedings are without any  
7 evidentiary foundation.

8 81. In the Coroner's Anesthesiology Consult, drafted by Dr. Selma  
9 Calmes, she states on page one that she has reviewed "a 1 ½ page anonymous  
10 letter to the Coroner by staff who were apparently present during the procedure."  
11 Dr. Calmes says the Anonymous Letter "appears to be written by people familiar  
12 with the OR and anesthesia routines." However, Dr. Calmes never verified  
13 anything about the letter, neither its author, nor its accuracy.

14 82. The Surgical Consult states:

15 "I have discussed the case and autopsy findings with Drs. Djabourian  
16 and Marinovich. The pending cause of death is hemorrhage (from  
17 laparoscopic surgery) and the likely manner of Death will be Accident. I  
18 also reviewed an anonymous letter sent here which outlines various  
19 shortcomings of the "1-800-get-thin" surgery centers.... My opinion agree  
20 [sic] with reporting this case to the California Medical Board for gross  
21 negligence with incompetence. I suggest that the anonymous letter be  
22 submitted to the Board."

23 83. The Coroner's illegal site inspection (see ¶¶ 39-45, *supra*)  
24 demonstrated that the accusations of the Anonymous Letter were untrue.  
25 Nonetheless, defendants have continued to utilize the refuted and contradicted  
26 Anonymous Letter as the basis for their findings.

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84. The Rojeski Final Report prepared by these five contributing defendant authors from the Coroner's Office does not indicate any effort to verify the contents of the Anonymous Letter, nor does it reflect information available that flatly contradicted the Letter's allegations. At a minimum, the Report should reflect such contradictory evidence as well as the efforts made to verify the allegations (and the results of such efforts). Neither the Surgical Consult nor the Anesthesia Consult demanded or required such verification. If there was such an effort, the results must be placed in the Report. The absence of verification creates an extreme departure from the standards of practice in autopsy findings.

**Plaintiff Valley Retains Independent Medical Experts to Review the Coroner's Rojeski Final Report**

85. In response to the seriously flawed Rojeski Final Report released confidentially to Valley's legal representatives on January 15, 2013, Valley responded by providing independent surgical and anesthesiology reviews of the report as follows from Dr. Michael Sedrak (Exhibit "7"), Dr. Michael Fishbein (Exhibit "9"), Dr. Ivan Hronek (Exhibit "8"), Dr. Cyril Wecht (Exhibit "10"), Dr. Terry Simpson (Exhibit "12"), Dr. Juan Felix (Exhibit "13") and Dr. Mirali Zarrabi (Exhibit "14") (collectively "Valley's Independent Experts").

86. Valley's Independent Experts were highly critical of the Coroner's gross error in claiming the surgery lasted 1 ½ hours beyond 9:45 a.m., when the anesthesia and the surgery procedure actually stopped. The medical records were unambiguous that the surgery lasted from 9:15 a.m. until 9:45 a.m., and that the patient recovered from anesthesia following surgery until she arrested at 10:55 a.m. and was transported to West Hills Medical Center at 11:15 a.m.

87. The findings of Valley's seven independent experts, which directly contradict the five authors of the Coroner's Rojeski Final Report, are significant

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1 for several reasons. First, with the surgery only lasting 30 minutes instead of two  
2 hours, it explains why the attending surgeon and the attending anesthesiologist did  
3 not see or notice any unusual bleeding: Ms. Rojeski did not suffer any  
4 complications until approximately 10:55 a.m., over an hour after the surgery had  
5 ended and she was "closed up."

6 88. Second, as a corollary to the above, Ms. Rojeski was neither awake  
7 during the surgical procedure, nor was she "awake and feeling pain as she  
8 proceeded along the path to her death over the next 1 ½ hours," as outrageously  
9 claimed by the Rojeski Final Report. Valley's independent experts show that by  
10 correctly reading the stop time in the medical records, the anesthesia was  
11 appropriately stopped at 9:45 a.m. and was not stopped prematurely, recklessly or  
12 negligently as claimed by Dr. Calmes and her four colleagues from the Coroner's  
13 Office.

14 89. Third, these erroneous factual findings created by Dr. Calmes and  
15 blindly repeated by the other four authors of the Rojeski Final Report destroy the  
16 scientific and legal validity of the Report. Each one of the Coroner's investigative  
17 team repeated the same erroneous factual finding regarding the stop time in  
18 making their conclusions as to the cause of death.

19 90. Valley's Independent Experts were highly critical of the Coroner's  
20 Report use of the Anonymous Letter in reaching the Report's conclusions. The  
21 reviewers pointed out that, after 17 months of investigation (now 19 months),  
22 none of the claims from the Anonymous Letter were ever verified. Indeed, the  
23 equipment logs at Valley showed the accusations were incorrect, and there was no  
24 evidence to support the letter's claims that oxygen tanks were empty, equipment  
25 malfunctioned, fluids spilled on the floor, the anesthesiologist wasn't paying  
26 attention, or that the time of Rojeski's coronary arrest was inaccurate.

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91. Valley presented its first expert report to the Coroner's Office on or about January 24, 2013. Valley's legal representatives personally delivered the expert report prepared by Dr. Michael Sedrak to the Coroner's Assistant Chief Investigator, Ed Winter. Upon being handed Dr. Sedrak's report, Investigator Winter responded that the Coroner's Office was going to issue the Rojaske Final Report without any modification. Investigator Winter further added that Valley's submission of expert reports, along with Rojaske's prior medical records, would, at best, possibly result in the issuance of a supplemental report. Investigator Winter also repeated his warning that the Rojaske Final Report had been shared with Valley and its legal representatives under a confidentiality mandate; any release or disclosure or discussion with a third party, besides a retained expert, would result in the Coroner's Office immediately publicly distributing the Rojaske Final Report.

92. Valley provided a total of seven independent expert reports to the Coroner's Office which categorically and unequivocally repudiated the findings of the Rojaske Final Report. Indeed, two of the retained experts, Dr. Fishbein, and Dr. Felix, are Deputy Medical Examiners to the Coroner's Office, just like Dr. Calmes.

93. On January 31, 2013, Kenneth Maranga, Esq. informed Valley's counsel, Centurion Law Group, that his office was now the retained counsel for the Coroner's Office. By phone Mr. Maranga also twice repeated the mantra stated by Investigator Winter, that the result of Valley's responses to the Rojaske Final Report would, at best, be discussed in a supplemental report to be subsequently issued by the Coroner's Office and that the Rojaske Final Report was not going to be revised or modified from what had been shown to Valley on January 15, 2013. Mr. Maranga confirmed that position again in a follow up letter

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1 he sent later that day. *See Exhibit "11" attached hereto and incorporated herein.*<sup>6</sup>  
 2 Maranga also stated that any future submissions by Valley regarding the Rojascki  
 3 matter had to be submitted through his office.

4 94. Valley's Independent Expert Reviewers have declared that the mode  
 5 of death was an "accident," and that the Coroner's conclusions are based upon  
 6 errors regarding the end time of surgery and unsubstantiated claims from the  
 7 Anonymous Letter.

8 **The Coroner's Imminent Threat to Issue the Flawed Rojascki Final**  
 9 **Report**

10 95. Valley's Counsel, Centurion, has asked Mr. Maranga, on four  
 11 different occasions between February 18 and March 11, 2013, when the Coroner's  
 12 Office would finish its review of Valley's Independent Expert Reports. Mr.  
 13 Maranga has only replied that the matter is still under review. Additionally,  
 14 Centurion has also asked Mr. Maranga in three separate e-mails whether or not the  
 15 matter has been referred to the California Medical Board as repeatedly  
 16 recommended in the Rojascki Final Report. Mr. Maranga stated he would check  
 17 with his client, the Coroner's Office, but has failed to provide a substantive  
 18  
 19

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20 <sup>6</sup> On February 1, 2013, counsel for Plaintiff Valley, Konrad Trope, Esq., of Centurion  
 21 Law Group, P.C., sent an e-mail to the Defendant County's retained counsel, Ken  
 22 Maranga. In that e-mail, Mr. Trope reconfirmed Mr. Maranga's previously stated position  
 23 that the Coroner's Office was not going to modify or revise the Rojascki Final Report. On  
 24 February 8, 2013, in response to Mr. Trope's request for access to the slides, photographs  
 25 and tissue samples that are referenced in the Rojascki Final Report, Mr. Maranga stated:  
 26 *"As you have been advised, The LA County Coroner is in the process of re-reviewing its  
 findings and conclusions. This may, or may not result in modified opinions and  
 conclusions. Until such time as that process has been completed, the Coroner's Office  
 advises it will not permit access to slides, or photographs."*

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1 response. The fact that Coroner's Office refuses to substantially respond to these  
2 reasonable inquiries compels Valley to seek an application for injunctive relief.

3 96. In addition, over the past 19 months, the Joint Commission, the  
4 accreditation agency which oversees medical facilities like Valley, pursuant to  
5 *Cal. Health & Safety Code § 1248.4*, has repeatedly informed Valley that it is  
6 awaiting the issuance of the Coroner's Rojeski Final Report. The Joint  
7 Commission has made its position quite clear that Valley's continued accreditation  
8 hinges on the outcome of the Coroner's Rojeski Final Report.

9 97. The Joint Commission is authorized by the California Medical Board  
10 - Division of Licensing, to oversee the accreditation of ambulatory surgery centers  
11 in California, such as Valley. *See Cal. Health & Safety Code § 1248.4*.

12 98. Because the Coroner's Office leaked the contents of the erroneous  
13 and flawed Rojeski Final Report to Rojeski's heirs in early January 2013,  
14 Rojeski's heirs, instead of settling their wrongful death lawsuit filed in September  
15 2012, have announced that they will be amending their complaint to seek punitive  
16 damages and will be continuing their lawsuit, thus unnecessarily subjecting Valley  
17 to additional damages and legal fees attributable to the Constitutional violations  
18 more fully described herein below.

19 **Declaratory and Injunctive Relief, Irreparable Harm, Damages Suffered**  
20 **By Plaintiff and Color of Law**

21 99. As a result of the conduct described above, Plaintiffs have been and  
22 continue to be injured, including suffering loss of income, lost profits, damage to  
23 its professional reputation, damage to its goodwill, damage to its business  
24 operations, damage to its ability to effectively recruit physicians and staff as a  
25 medical facility, expenses in retaining consultants and attorneys to attempt  
26 (unsuccessfully) to convince the Coroner's Office and its representatives that its

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1 statements and conclusions are false and without any evidentiary foundation,  
2 diversion of resources (including staff and professional time) from carrying out its  
3 normal medical activity to address the problems occasioned by Defendants'  
4 conduct, injury to its constitutional rights, the exacerbation of claims in the  
5 Rojeski lawsuit that it was responsible for her death, and the need to prepare to  
6 defend itself before the relevant licensing/accreditation authorities in California, to  
7 name some of the injuries caused to date.

8 100. Plaintiff is entitled to declaratory relief with respect to the  
9 unconstitutionality of the conduct of the Coroner's Office and its agents and with  
10 regard to the falsity of the evidence that forms the basis for the Coroner's Report,  
11 and an injunction preventing the continuing participation of the Coroner's Office  
12 and its agents in the investigation into the Rojeski death, including participation in  
13 releasing any reports related thereto. The pattern of unconstitutional and unlawful  
14 conduct in which the Defendants have engaged demonstrate that they are so biased  
15 and irrationally and arbitrarily hostile to Plaintiff as to disqualify them from any  
16 such further role.

17 101. Without such a declaration and injunction, Plaintiffs will be  
18 irreparably harmed. It will face the ongoing threat that its business will be  
19 completely destroyed before it can successfully defend itself. Official issuance of  
20 the current report, based on fabricated evidence and information whose falsity at  
21 this point is beyond dispute, would almost certainly lead to withdrawal of Valley's  
22 licensure/accreditation in the short term and possibly longer, with the likely effect  
23 of destroying what is left of its business. If this false Coroner's Report is released,  
24 as threatened by the Coroner's Office, it will almost assuredly lead to the financial  
25 collapse of Valley, a collapse from which it is unlikely that it could ever recover  
26 even if ultimately vindicated.

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1        102. All of the Defendants, while often described in the past tense  
 2 throughout the complaint, continue to engage in the conduct set forth herein to the  
 3 present, and, unless enjoined by this court, will continue to do so. The conduct of  
 4 defendants as alleged herein has been, continues to be and, unless enjoined by this  
 5 court, will continue to be deleterious to the Plaintiff and its fundamental rights.  
 6 Unless they are restrained from doing so, Defendants will continue to engage in  
 7 such unlawful conduct.

8        103. Unless this Court acts to enjoin the unlawful conduct described  
 9 herein, Plaintiff will continue to suffer irreparable harm. Plaintiff has no adequate  
 10 remedy at law. Damages alone are insufficient in light of the continuing violation  
 11 of its constitutional rights and the threat to its very existence as a viable entity.

12        104. Plaintiff seeks injunctive relief under both federal and state law.

13        105. In engaging in the conduct described above, all of the Defendants,  
 14 when sued in their individual capacity, acted willfully, wantonly, maliciously,  
 15 oppressively, and/or with conscious or reckless disregard or deliberate  
 16 indifference to the Constitutional rights of Plaintiff Valley. Therefore, Plaintiff  
 17 Valley is entitled to seek punitive damages against said Defendants.

18        106. At all times herein, the individual Defendants acted or purported to  
 19 act within the course or scope of their employment or agency and were acting  
 20 under color of law as employees or agents of the County Coroner's Office, or  
 21 persons acting in concert with, and under the direction and control of, the County  
 22 Coroner's Office.

23 ///

24 ///

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COMPLAINT FOR DAMAGES  
 AND INJUNCTIVE RELIEF

**FIRST CLAIM FOR RELIEF – VIOLATION OF CONSTITUTIONAL  
RIGHTS UNDER 42 U.S.C. § 1983**

***(Damages Against All Defendants Sued In Their Individual  
Capacity)***

107. Plaintiff alleges and incorporates, as though fully stated herein, all the foregoing and any subsequent allegations and paragraphs set forth in this Complaint.

108. Defendants, and each of them, personally and/or as part of a conspiracy, acted, under color of state law, to violate Plaintiff's constitutional rights, including but not limited to:

- a. Violate its due process right to a governmental investigation not based on false and/or fabricated evidence;
- b. Violate its due process right to an unbiased governmental investigation not based on false and/or fabricated evidence;
- c. Violate its due process right to not have exculpatory evidence destroyed in bad faith;
- d. Violate its First Amendment and due process rights to petition the government and to have access to the courts;
- e. Violate its First Amendment rights to engage in lawful speech without being retaliated against for doing so;
- f. Violate its First Amendment rights to engage in lawful speech without having its right to do so infringed upon and chilled by the actions of governmental agents or employees;
- g. Violate its due process rights to petition the government and to have access to the courts;

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1 h. Violate its Fourth Amendment right not to be subjected to an  
 2 unlawful search and seizure;

3 i. Violate its equal protection and/or due process right not to be  
 4 singled out for irrational and/or arbitrary discriminatory  
 5 treatment.<sup>7</sup>

6 109. Defendants' actions violated Plaintiff's rights under the First, Fourth,  
 7 Fifth and Fourteenth Amendments to the United States Constitution. To the extent  
 8 that any Court were to determine that the foregoing claims are appropriately  
 9 brought under a different or additional constitutional right not expressly named  
 10 above, such claims are also brought under such alternative or additional  
 11 provisions.

12 ///

13 ///

14 ///

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21 <sup>7</sup> To avoid any possible confusion, Plaintiff Valley is claiming to be a class of one for  
 22 equal protection purposes because Valley and its medical staff was repeatedly subjected  
 23 to intentional treatment that was clearly different from others similarly situated, and there  
 24 is no rational basis for the difference in treatment. In other words, Valley was subjected  
 25 to an ongoing investigation by the Coroner's Office without any legitimate basis for doing  
 26 so, and the Coroner's Office has subsequently, in the Rojeski Final Autopsy Report,  
 recommended that Valley and its medical staff be referred for further prosecutorial  
 actions on the basis of deliberately fabricated false evidence.

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**SECOND CLAIM FOR RELIEF – VIOLATION OF CONSTITUTIONAL  
RIGHTS UNDER 42 U.S.C. § 1983**

***(Monell Damages Against The County of Los Angeles, the County  
Coroner's Office, And Defendant Lakshmanan Sathyavagiswaran  
In His Official Capacity, and Against Defendant Sathyavagiswaran  
In His Individual Capacity for Supervisory Liability)***

110. Plaintiff alleges and incorporates, as though fully stated herein, all the foregoing and any subsequent allegations and paragraphs set forth in this Complaint.

111. Defendant County of Los Angeles, County Coroner's Office and Defendant Lakshmanan Sathyavagiswaran (hereafter the "*Monell* Defendants") are sued under *Monell v. Department of Social Services of the City of New York*, 436 U.S. 658, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978).

112. On information and belief, Defendant Sathyavagiswaran was, at all times herein relevant, an employee of the Coroner's Office and had the final policy making authority for the conduct of the Coroner's Office and its investigation, including having authority over the other individual Defendants named herein. Defendant Sathyavagiswaran, as the policy maker for the County Coroner's Office, maintained, enforced, tolerated, ratified, permitted, approved, acquiesced in, and/or engaged in the conduct and constitutional violations alleged above, thereby making the County directly liable for these actions.

113. Alternatively, the ongoing conduct over 19 months of repeated constitutional violations of Plaintiff's constitutional rights – separated in time and of varying types – constitute a custom and practice sufficient to make the County directly liable under *Monell* for the conduct alleged herein.

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114. Additionally, Defendant Sathyavagiswaran is individually liable under the doctrine of supervisory liability because (1) he was personally involved in the constitutional violations alleged herein (including but not limited to the use of fabricated and false evidence), or (2) he was aware of and acquiesced in the constitutional violations and acted or failed to act with a reckless or callous disregard for Valley's rights. Despite knowledge of the violations alleged herein, he took no action of any kind to prevent or correct them. In short, Defendant Sathyavagiswaran was unconstitutionally silent in preventing or correcting these violations.

**THIRD CLAIM FOR RELIEF – VIOLATION OF STATE LAW**  
*(Against All Defendants For Injunctive Relief With Amendments  
 To Be Added For Damages Claims Once Plaintiff Is Able to File  
 The Necessary Administrative Claims Without Fear Of Retaliation)*

115. Plaintiff alleges and incorporates, as though fully stated herein, all the foregoing and any subsequent allegations and paragraphs set forth in this Complaint.

116. Defendants violated many state laws governing the conduct of the Coroner's Office, some of which provide a partial basis for injunctive relief, provide protected liberty and/or property interests, and provide potential claims for damages.

117. Once conferred, California law provides a physician at least a protected property interest in his/her license to practice medicine and provides an accredited medical facility at least a protected property interest in his/her/its accreditation.

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118. Other relevant state laws include, but are not limited to, (1) Cal. Gov't Code § 27491.4 (coroner must act in accordance with medico-legal practice); (2) Cal. Gov't Code § 27491.5 (coroner's report must be in accordance with facts ascertained from inquiry, autopsy and other scientific findings); (3) Cal. Gov't Code § 27491.45 and Cal. Health & Safety Code § 7151.2 (regarding appropriate organ harvesting); (4) Civil Code § 815.6 (violation of mandatory duty), and (5) Cal. Civil Code § 52.1 (use of threats, intimidation or coercion to interfere and attempt to interfere with exercise of rights secured by Federal or State Constitution or law), as well as violation of the California Constitutional protections for freedom of speech and petition, freedom from unlawful searches and seizures, and the right to due process and equal protection of the law.

119. Due to the intimidating and harassing conduct of Defendants as previously alleged, Plaintiff has not filed an administrative claim under Govt. Code § 910 for damages, and accordingly does not currently allege state law damages claims. However, Plaintiff, with the anticipated protection of the court as requested in this complaint, intends to proceed to file such claims and to move to amend the complaint to add state law damages claims at the appropriate time.

#### **FOURTH CLAIM FOR RELIEF – INJUNCTIVE RELIEF AND DECLARATORY RELIEF**

##### ***(Against All Defendants For Injunctive and Declaratory Relief)***

120. Plaintiff alleges and incorporates, as though fully stated herein, all the foregoing and any subsequent allegations and paragraphs set forth in this Complaint.

121. Based on the ongoing violations of law and of Plaintiff's constitutional rights, and the irreparable harm Plaintiff will experience if this

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1 Court does not act, and the fact that there is no adequate remedy at law, Plaintiff  
 2 Valley seeks an injunction against the Coroner and its staff to prohibit it from:

3 a. any further role in the investigation into the death of Paula Rojas. <sup>8</sup>

4 and

5 b. releasing the Coroner's Final Rojas Report.

6 122. In the event the Court does not grant an injunction, then Plaintiff  
 7 seeks declaratory relief stating that 1) it violates Plaintiff 's constitutional rights,  
 8 including its right to due process of law, for the Coroner's Office to assert in any  
 9 official report or proceeding that Paula Rojas's surgery lasted more than 30  
 10 minutes, or that she was in surgery or under anesthesia at the time of her cardiac  
 11 arrest at 10:55 a.m., because that is a statement unsupported by any evidence and  
 12 is directly contrary to all available medical records; 2) it violates Plaintiff's  
 13 constitutional rights, including its right to due process of law, for the Coroner's  
 14 Office to quote from or rely on the unverified and unsupported Anonymous Letter,  
 15 which could only be validly used, to the extent it could be used at all, as an  
 16 investigation tool, the contents of which have to be, but have not been,  
 17 independently verified; and 3) it violates Plaintiff's constitutional rights, including  
 18 its right to due process of law, for the Coroner's Office to forward to any  
 19 governmental body referrals for criminal, civil, or administrative proceedings that  
 20 rely in any respect on the unsupported statements described in ¶ 124(1) and (2).

### 21 PRAYER FOR RELIEF

22 Plaintiff seeks judgment as follows:

23  
 24 <sup>8</sup> This would leave the County free, if it so decided, to choose an independent or out of  
 25 County Coroner's Office, which, after appropriate investigation, would be free to issue its  
 26 own Report.

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- 1 A. Preliminary and permanent injunctive relief prohibiting the Los Angeles  
2 County Coroner's Office from any further role in the investigation into the  
3 death of Paula Rojas, including releasing its report regarding that death.  
4 B. In the event that injunctive relief is not granted, declaratory relief as  
5 described in ¶ 124, *supra*.  
6 C. Compensatory, general, and special damages against all Defendants, and  
7 each of them, in an amount according to proof;  
8 D. Punitive and exemplary damages against all Defendants sued in their  
9 individual capacities, and each of them, in an amount according to proof;  
10 E. Pre-judgment interest according to proof;  
11 F. Reasonable attorney's fees and expenses of litigation as allowed  
12 by 42 U.S.C. § 1988, California CCP § 1921.5, California Civil Code §  
13 52.1(h) and other applicable law;  
14 G. Costs of suit reasonably incurred;  
15 H. That Defendant Coroner's Office be required to pay any judgment  
16 pursuant to law.

17 DATE: 03/28/2013

Respectfully Submitted,

KAYE, MCLANE, BEDNARSKI &  
LITT, LLP

By: \_\_\_/s/ Barrett S. Litt \_\_\_\_\_  
Barrett S. Litt

CENTURION LAW GROUP, P.C.

By: \_\_\_/s/ Konrad L. Trope \_\_\_\_\_  
Konrad L. Trope

Attorneys for Plaintiff  
VALLEY SURGICAL CENTER, LLC

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DEMAND FOR JURY TRIAL

Plaintiff Valley Surgical Center, LLC demands a jury trial, as provided by  
R.38(a) Federal Rules of Civil Procedure.

DATE: 3/28/2013

Respectfully Submitted

KAYE, MCLANE, BEDNARSKI &  
LITT, LLP

By: \_\_\_/s/ Barrett S. Litt \_\_\_\_\_

Barrett S. Litt

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VALLEY SURGICAL CENTER, LLC

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Attorneys for Plaintiff

VALLEY SURGICAL CENTER, LLC

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